SC Budget and Control Board Division of Insurance and Grants Services Employee Insurance Program

033913 Optional Life and Dependent Life 674267 Basic Life

Notice of Continuation of Coverage

As a terminated employee you may be eligible to continue certain coverage you had in place under your employer's group plan(s). Options are explained below.

Life Conversion

Under the Life Conversion option, you may convert the full amount of coverage you carried under your employer's group plan to an individual Life policy (permanent insurance). The conversion policy accumulates a cash value and there are no mandatory age reductions. Coverage can continue with premium payment until the Scheduled Maturity Date at which time the Cash Surrender Value is paid to the insured (generally age 100). Evidence of insurability is not required to convert your coverage. Residents of New York, Minnesota, or West Virginia have the option for an 11-month term policy prior to the individual life policy becoming effective. **Premiums for a life conversion policy are significantly higher than your group plan rates.**

Attached is a form that contains additional information about continuing coverage. You can use this to request a quote and the necessary forms to enroll. To continue your coverage, **you must mail or fax this form to request the information within 15 days from the date of this notice or 31 days from the date of your group coverage termination, whichever is later.** Failure to comply with the timeliness requirement will result in denial of your request to continue coverage.

If you have questions about this information, your eligibility, or the status of any request you have submitted, please call a representative at 1-877-320-0484.

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clear form

Notice of Continuation of Coverage

EMPLOYER: Please complete the top portion of this form

Employee Name:_____ Date:_____

Last Day Worked (or date employee is no longer in an eligible class):_____

Date of Group Coverage Termination:_____

Contact Name _____ Contact Phone #:_____

Contact Fax #:_____Contact E-mail address: _____

To request a Life Conversion quote please complete the section below and mail or fax this form to the address / fax number indicated.

The Hartford, Portability and Conversion Unit, P.O. Box 248108, Cleveland, OH 44124-8108

Fax 440-646-9339, Phone 877-320-0484

Please note that you have 31 days from the date of your Group Coverage Termination OR 15 days from the date of this notice, *whichever is later*, to complete and submit this form.

***Employee*: Please complete this section and return entire page.**

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Yes, I am interested in receiving information of the coverage options checked below. Please send the information to my address as indicated.

☐ Life Conversion Quote

Please print the following:

Name: _____ Date of Birth: _____

Social Security #: _____ **(indicate last four numbers only)**

Address: _____

City:_____ State: _____ Zip Code:_____

Telephone Number: _____

Please print the name(s) and date(s) of birth for each dependent that may be eligible for coverage.

Name _____Relationship_____ Date of Birth _____

Name _____Relationship_____ Date of Birth _____

Name _____Relationship_____ Date of Birth _____

Name _____Relationship_____ Date of Birth _____

I understand that I have only 31 days from the date of my group coverage termination OR 15 days from the date of this notice, whichever is later, to complete and submit this form to The Hartford.

_____ _____

Signature (required) **Date**